International Rescue Committee

Rwanda Child Survival Program

Third Annual Report
October 2001- September 2002

Location: Kibungo Province, including the following health districts: Kibungo, Kirehe, Rwamagana and Rwinkwavu

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October 1, 2001 (Current Grant)

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September 31, 2005 (Current Grant)

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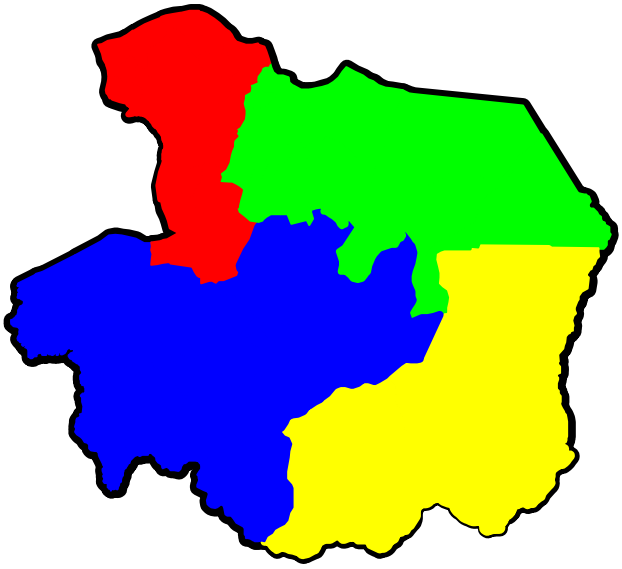
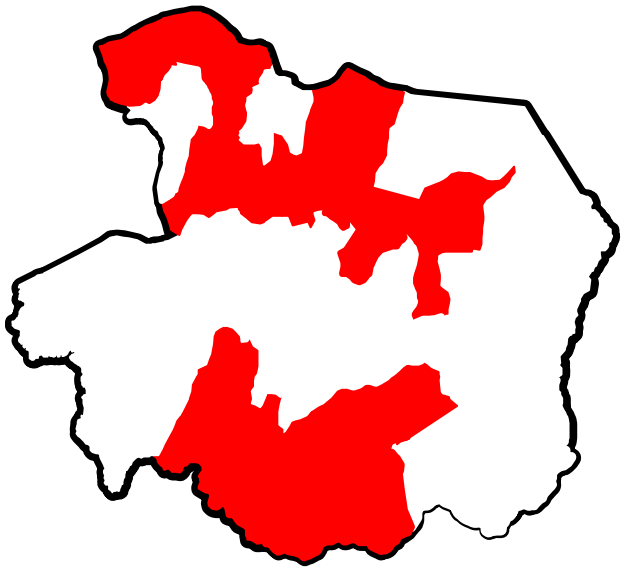
Prepared by: Eugene Twahirwa, National Health Coordinator, IRC Rwanda
Emily Sonneveldt, Health Coordinator, IRC Rwanda
Emmanuel d'Harcourt, Senior Child Survival Technical Advisor, IRC New York

GEOGRAPHIC LOCATION OF CHILD SURVIVAL ACTIVITIES
KIBUNGO PROVINCE
SEPTEMBER 2002

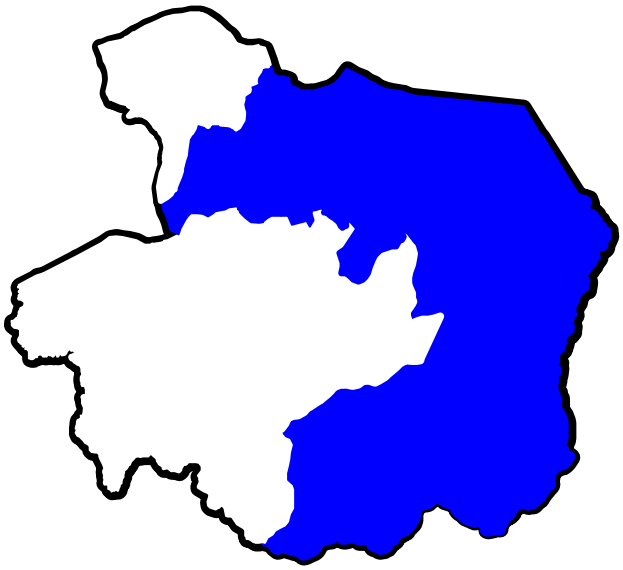


Kibungo Province health districts
- Rwamagana District
- Rwinkwavu District
- Kibungo District
- Kirehe District

Safe Motherhood program
(All four districts)



Nutrition Program
(Pilot areas in all 4 districts)



Malaria and Health Animator Program
(Rwinkwavu, Kirehe, and Rwamagana Districts)

Executive Summary

The Kibungo Child Survival Program began with an entry grant from USAID in October 1999. The program received a second cycle of funding in October 2001, after approval of the Detailed Implementation Plan. The program focuses on safe motherhood, nutrition, and malaria control. Program staff work closely with the Rwandan Ministry of Health, and program activities are integrated into district and health center schedules. In the last year, the project has witnessed a major expansion of its community nutrition activities, continued growth of its work with Traditional Birth Attendants, and the beginning of its malaria intervention.

Major successes have included:

- **Major expansion in growth monitoring coverage** through community growth promotion clinics, going from less than 1,000 a month over the previous year to over 6,000 children currently weighed each month. The increase has come from an expansion into new health centers (currently 11, up from 4 last year) and from an increase in growth monitoring coverage within the work areas from 22% to 41% for children under 3 years of age. Some of the growth promotion centers have expanded their activities to include cooking demonstrations and home visits by health animators.
- **Major improvement in prenatal coverage, obstetric referrals, and newborn care** through work with Traditional Birth Attendants (TBAs). Prenatal coverage in Nyarubuye Health Center, for example, has gone from 26% in December 2001 to 58% in June 2002. The proportion of TBA deliveries referred to health facilities has gone from 12% to 16%. The number of cesareans done in the province has risen to 556 over the last twelve months (October to September) from 415 in the preceding twelve months. In September 2002, 49% of newborns in our TBA work area were weighed at birth, up from 32% a year earlier.
- **Building capacity for data-based decision-making** at the district, health center, and community level. IRC has worked at these levels to use data – collected through community health information systems, PLA, and qualitative research – to identify problem areas and include community priorities in program planning. For example, IRC and district agents use data on malnutrition collected by community agents to identify problem areas, and to discuss causes and solutions.
- **Scaling up at the national level** of two community information systems developed by the Child Survival Program. For example, in the coming year the nutrition information system will be in all UNICEF growth monitoring sites in the country. Other tools currently in development for the program, such as Lot Quality Assurance Sampling (LQAS), may also be suitable for scaling-up.
- **Continued strengthening of local partnerships** at the community, facility, district and MOH level, increasing the chances that major program interventions will be continued after the current funding cycle. The strong partnership has led the Ministry of Health to approach IRC and its partners in Rwinkwavu District about making Rwinkwavu District one of the national pilot sites for implementation of IMCI, and the national pilot site for development of a curriculum for post-natal care. IRC has convinced the MOH to include community-level care in the curriculum.
- **Developing international partnerships** with other Child Survival Programs and Cooperative Agencies such as the Quality Assurance Project, with the goal of improving quality of programs and technical capacity.
- **Developing new program tools,** including counseling cards.

- **Initiating the program's malaria intervention**, with health animators selling impregnated bednets at the community level. A recent LQAS survey in Kirehe District showed 11% of children under 2 years of age sleeping under a correctly impregnated net, up from 3% for the province as a whole in 2000.

Major challenges also remain:

- **Dealing with the effects of government decentralization**, which has brought personnel instability and made coordination with different districts more difficult.
- **Developing the program's malaria component**, which remains timid compared with the nutrition and safe motherhood interventions.
- **Changing MOH policies** limiting the scope of community health work.
- **Beginning major interventions at the facility level**. Most of the program's work so far has concentrated on community work.
- **Improving the community health information systems** to make them easier to use.
- **Setting up realistic capacity-building and sustainability indicators** with the help of CSTS. Doing capacity assessment earlier has proven difficult, as the process cannot be started without a strong partnership already in place.
- **Revising some of the program indicators** to reflect changes in the program (changed partner priorities, the use of LQAS methodology).

We feel that continued close collaboration with local partners, combined with the development of specific tools such as community health information systems and LQAS methodology, will allow the program to offer several elements suitable for scaling-up, making major contributions to child survival not only in Kibungo, but also in the rest of the country.

Objectives

Please note that many of the current numbers come from the LQAS survey that was recently completed. They therefore apply to Kirehe Health District only, whereas the baseline numbers apply to the four districts in our work area. The population of Kirehe District is poorer, more rural, and more recently settled than that of the province as a whole. We will have to wait for surveys in the other 3 districts for a more definitive picture of progress over the last year. Baseline numbers are given for the province (P) and for Kirehe District only (K). Of note: all KPC numbers are for the age groups covered in the LQAS survey recently given. They may therefore differ from those given in the DIP, which were for the entire 0 to 23 months age range. Also, the Kirehe numbers come from only about 60 households in a cluster survey, and so should be interpreted with caution.

1. Nutrition

	Objective	Baseline	Current	2005 target	On Target?	Comments
1.1	To increase the proportion of mothers of children under 1 who take vitamin A within a month of delivery	31 (P) 28 (K)	24 (K)	60	?	Although the proportion appears to have fallen, this may be due to the fact that the 2002 national immunization days occurred two months before the current survey, whereas the KPC took place only a month after the 2000 national immunization days. In the DIP, we gave Vitamin A coverage outside of National Immunization Days; the corresponding LQAS data will be available once computer data entry is complete.
1.2	To increase the proportion of children 12 to 23 months taking vitamin A every 4 months	86 (P) 76 (K)	73 (K)	50	?	See comment above.
1.3	To decrease the proportion of underweight children (below 80% of weight-for-age median)					There has been a marked improvement in the nutritional situation. Most of this improvement can be attributed to the end of a three-year drought, and a corresponding improvement in food security, rather than to IRC or district activities. The data from the community clinics, however, has given the Health Districts the ability to track the situation, allowing them to anticipate a worsening in the food security situation in the future, and to target the areas worst hit.
	Program data, Rwamagana District, children under 3	43	18	20	Y	
	UNICEF (baseline) and LQAS population-based survey data	31 (P) 52 (P)	17 (K) 26 (K)	20	Y	For children 0 to 11 months For children 12 to 23 months

1.4	To increase the proportion of children 0 to 11 months having breastfed within an hour of delivery	31 (P) 25 (K)	19 (K)	50	N	Although the results from Kirehe may not reflect the entire work area, clearly more work needs to be done to achieve our target. One of several strategies will be emphasizing this message during TBA refresher trainings and during regular meetings.
1.5	To increase the % of mothers of children 0 to 11 months who take iron for at least a month during pregnancy	5 (P) 6 (K)	7 (K)	20	N	Much more progress needs to be made, especially given that well over 50% of mothers attend prenatal consultations. As the Kirehe District leader stated during the recent LQAS survey, the major problem seems to be that health center staff do not give iron despite women's readiness to take it.

2. Maternal and newborn health

	Objective	Baseline	Current	2005 target	On Target?	Comments
2.1	% of mothers of children 0 to 11 months reporting at least 2 TT immunizations for last pregnancy	Not comparable	39 (K)	45	Y	The indicator is problematic because the questions asked in the baseline are not comparable to the questions asked in the recent survey, and because of the considerable variation with which TT immunizations are recorded. The Kirehe, Kibungo, and Rwinkwavu District leaders have committed themselves to improving the quality of prenatal records to minimize such problems in the future. The introduction of a goal-based approach to prenatal visits will be the primary strategy to improve this indicator.
2.2	% of obstetric transfers from community to health facility, as measured by TBAs	6 (P)	16 (P)	15	Y	Three years of steady work with TBAs, combined with the active involvement of the health districts, have led to a marked increase in obstetric transfers. IRC and its MOH partners are now working to measure and improve the appropriateness of the transfers—are the right women being transferred?
2.3	# of cesarean sections done in hospitals	415 (P)	556 (P)	?	Y	This indicator, new since the DIP, is an effort to measure whether the increased TBA referrals are leading to improved outcomes. We are using data from the 2 hospitals in the province, which are the only facilities that perform the procedure in the province.
2.4	Improved quality of care at health centers	Pending				IRC is now beginning a relationship with PRIME to improve the quality of reproductive health care at health centers, beginning with the development of appropriate indicators.

3. Malaria control

	Objective	Baseline	Current	2005 target	On Target?	Comments
3.1	# of deaths from febrile illness, per year, per 1,000 children under 5	Pending				Because of the changing geographic area as the program expands, comparisons across time are not valid. We are waiting for full coverage of the health animator system to begin tracking this indicator.
3.2	Proportion of children under 2 who slept under a correctly impregnated mosquito net last night	3 (P) 0 (K) 8 (P) 0 (K)	11 12	20	Y	For children 0 to 11 months. For children 12 to 23 months.
3.3	Improved quality of malaria case management at the health centers	Pending				Indicators are currently being developed, in partnership with the Quality Assurance Project, the Ministry of Health, and the Health Districts.

4. Capacity-building and sustainability

The Child Survival Program is currently reviewing its capacity-building and sustainability indicators in light of the recent CSTS tool. We are planning to use the process of assessing IRC and its partners' initial capacity to also define indicators.

B. Major constraints and solutions

1. Government Policy

Government policy towards community-based health programs has limited some aspects of the Child Survival Program. Examples of policy with which IRC – and, in many cases, its local partners – disagrees include:

- **The prohibition of any distribution of medicine by community health workers**. IRC feels that empowering caregivers and community agents to treat some illnesses, such as mild diarrhea and uncomplicated malaria, would prevent many child deaths. We also feel that such a policy, by giving more voice to community health agents trained in the recognition of critical danger signs, may actually increase use of health facilities by seriously ill children.
- **The prohibition of distribution of iron and presumptive anti-malarial treatment to pregnant women by TBAs**. Given the strong reluctance of mothers to have prenatal visits before late in the third trimester, IRC feels that TBAs are a crucial ally in providing some prenatal services, such as distribution of iron, at the appropriate early stage in pregnancy. We believe distribution of anti-malarials by TBAs is also feasible, but it will probably not be possible to change MOH policy in this regard.
- **Regarding Community Health Workers as volunteers**. While this policy is understandable given the MOH's severe resource constraints, IRC feels it will be difficult to sustain the current program with Community Health Workers as unpaid broadcasters of health messages whose main rewards are community recognition and an occasional t-shirt. We believe that motivation of health workers must be looked at carefully. Possible solutions include:

    1. Payment for preventive services – such as weighing, distribution of Vitamin A, and help in organizing immunization sessions – by the clients of these services. IRC and the districts' experiences to date have shown that women are willing to pay for quality community-based services.
    2. Regular training.
    3. An expanded role including some curative activities, which can also generate revenue.
- **Unrealistic expectations for community nutrition workers**. MOH policy is for community workers to weigh over a hundred children in each growth monitoring session, which we feel is incompatible with adequate counseling. MOH policy in this regard is already changing.

Solutions: Some of these policies are beginning to change. IRC's information system for community growth monitoring has been accepted as the national standard, and with it the recognition that community nutrition clinics will need to weigh fewer children at one time so that adequate time can be spent counseling. To address other policy issues, IRC is planning to advocate directly with high-level MOH officials, using the credit gained by its current activities, which have received high-level recognition from the MOH's nutrition, quality of care, and reproductive health divisions. Also, the country's gradual adoption of IMCI,

including community IMCI protocols, is likely to give an expanded role to community workers.

2. Government Decentralization

In 1999, the Rwandan Government began a new decentralization strategy to disseminate decision-making power and resources from the national to the local level. As it has become implemented in the last year in Kibungo province, decentralization has had a number of unfortunate consequences on the health sector in Kibungo, including:

- **The marginalization of the provincial health office**, which previously served a crucial role as a technical resource and as a coordinator of health districts, as well as a partner to IRC staff.
- **Health Districts left without any effective supervision**, leading some to thrive and some to flounder.
- **Health Districts left without any government funding**, pending the resolution of a disagreement between the national parliament and the MOH regarding their role. Currently, the parliament does not recognize health districts, even though they coordinate most health activities in the provinces, and so has refused to fund them.
- **Corresponding personnel instability**, including staff resignations, making it harder to develop the personal relationships and continuity on which partnership is based.

Solutions: IRC has responded by strengthening its link with each district and with health center staff, since, whatever form the MOH finally takes, health centers will continue to be the main implementers of health activities.

3. Positive developments

It would not be appropriate to discuss major constraints without also referring to factors which have helped the Child Survival Program:

1. **Strong involvement of government partners**. At both the District and Central Level, IRC's MOH partners have shown full dedication to the Child Survival Program.
2. **High interest among Community Health Workers**. Community Health Workers, who had been ignored or paid lip service in many previous health programs in Kibungo, have responded extremely favorably to the attention paid to them by health center staff. Their enthusiasm has been the main engine behind the growth of the program.
3. **Improved coordination with other Child Survival PVOs**. The presence of other CS PVOs – most notably Concern Worldwide, whose program in Kibilizi Health District is very similar to the IRC's – has allowed IRC to improve its indicators and get more MOH attention. It has also allowed for sharing of technical resources, most recently in the form of help from an LQAS expert.
4. **The development of partnerships with USAID cooperating agencies**, such as the Quality Assurance Project, is allowing the program to improve not only its own capacity, but that of its government partners as well.

C. Technical Assistance Needs

1. Hearth.

IRC is committed to the introduction of Hearth methodologies in its nutrition program. Given the lack of in-house expertise, we will solicit the help of an external consultant.

2. Quality measurement and improvement.

IRC has recently agreed to work with the Quality Assurance Project (QAP) to develop and implement tools to improve quality of health services at both the facility and the community level. The partnership will allow IRC to improve its programs, while helping the QAP extend its reach from one district (Rwamagana) to the entire province. The partnership will operate both at the national level and at the headquarters level in the U.S.

3. Measurement of capacity.

In the initial phases of the partnership, when trust was still being built, capacity measurement proved difficult to implement. At this stage, IRC staff feels that capacity measurement, both for IRC and its partners, is not only possible, but urgently needed. We feel CSTS would be the most appropriate technical resource in this endeavor.

D. Substantial Changes

The major elements of the program have remained the same, including:

- The choice of technical interventions
- The monitoring and evaluation plan, based on a combination of community and facility-based data, as well as LQAS surveying
- The management plan
- The major strategies, which include close partnership with health districts, health centers, and community health workers.

Inevitably, some changes have been made to some indicators, based on the experience of the last two years since the DIP was written. Although we have and will continue to inform USAID of these changes, we feel they are on a limited scale and do not merit a revision of the Cooperative Agreement.

E. Mid-term Evaluation Recommendations

As the program has currently completed only one year of its current four-year funding cycle, and because the current cycle involved substantial changes from the 2-year entry grant, IRC will conduct its midterm evaluation in August and September of 2003. IRC plans to use the participatory evaluation model, with an external evaluator serving as a facilitator, allowing IRC staff and its partners a full voice in the evaluation. We are currently in the process of identifying a consultant for this evaluation.

F. Phase-Out Plan

IRC's phase-out strategy, as outlined in the DIP, is based on partnership, with all activities being carried out by MOH and community partners, and IRC providing gradually decreasing support. More specifically, IRC's phase-out strategy involves:

- Involvement of district partners at all stages of program development and implementation
- Training of district partners to collect, analyze and act on data through the LQAS method
- Training of community partners to collect, analyze and act on data collected by Community Health Workers
- Having a reasonable support policy, which does not include the use of per diems and other unsustainable motivation
- Developing a realistic and sustainable set of incentives for Community Health Workers
- Development of low-cost, realistic supervision systems for Community Health Workers
- Improving management capacity at the community level through the creation, training, and support of associations for Community Health Workers.

G. Factors that have affected the program

1. **Financial management:** no changes

2. **Human resources**: no staff members have been let go in the last 12 months. The stability in program staff has been a major positive factor, helping to build morale within the IRC child survival team as well as continuity with partners. However, the expansion of the program has been extensive, and more staff will be needed. IRC is currently searching for match funds to support more staff.

3. **Communication**: no major changes.

4. **PVO collaboration**: the start-up of two more CSGP-funded Child Survival Programs in Rwanda, and the formation of a Child Survival Consortium at the national level, has provided a venue for the four Child Survival Programs in Rwanda to share experiences, harmonize key indicators, and gain recognition with other organizations. The inclusion of USAID and UNICEF has added technical support and the opportunity for further partnership building.

5. **Local partner relationships**: As stated elsewhere in the report, continued strengthening of partnership at the MOH, district, and community level has been the major engine behind the expansion of the program.

H. Successes, new methods, and potential for scale-up

Last year, the protocol for community-based growth promotion, developed by IRC, was adopted by the MOH nutrition division as the national standard. A comparison of the several community-based growth promotion programs operating in Rwanda showed that the Kibungo program was the only one collecting simple, reliable information in an easy-to-use format. This year, the IRC information system for Health Animators (all-purpose Community Health

Workers) was used as the basis for a major revision of the previous system, which had proved unworkable. Of note, both of these systems were recently in a paper presented at the "Data for Action" Conference sponsored by CSTS in September 2002.

In addition, IRC feels several aspects of its program, currently under development, may be suitable for scale-up. These include:

1. **LQAS**: At the time of the writing of this report, IRC is organizing an LQAS survey and training-of-trainers with participants from its work area, from other Child Survival Programs in Rwanda, and from other African countries. Although the training is not fully completed, the initial reaction has been extremely positive, and two districts have already asked for assistance in implementing an LQAS-based survey.
2. **Community and household IMCI**: Although the MOH officially supports community-based nutrition, there has been little effort in linking growth-monitoring with other key c-IMCI interventions, such as home use of anti-malarials. IRC intends to pioneer this approach in the country in preparation for Rwanda's official implementation of IMCI, expected in 2003 or 2004.
3. **Use of the "target-weight" method**. This method, developed by the Manoff Group, focuses on a child's growth in the past month and the coming month, rather than on the child's present status. IRC is currently piloting the method in two health districts, and is beginning to collaborate with the Manoff Group to formally evaluate its effectiveness.
4. **Post-natal program**, including a training curriculum at both facility and community level.
5. **TBA program**. The program goes beyond the information system, and includes job description, definition of TBA roles both within the community and at the health facility level, and relationships between TBAs and health center staff. IRC is currently in contact with the MOH reproductive health division, which is interested in developing national norms for TBAs and has requested IRC's assistance.

I. Other relevant aspects of the program

1. Participation in national forums

Close collaboration at the district level and a reputation for backing up programs with appropriate data collection has led the MOH to invite IRC Child Survival staff to many workshops and planning meetings at the national level, including:

- Elaboration of national nutrition policy
- National protocol for the reduction of anemia
- IMCI
- Finalization of training module for peer educators related to HIV/AIDS.

2. Research

Research studies undertaken through the program in the past year include:

- Qualitative research on specific barriers to contraceptive usage and possible solutions
- Malaria prevalence study among pregnant women at PNC.

Conclusion

In summary, the Child Survival Program has experienced considerable progress in the past year, including the expansion of its nutrition programs, demonstrable results from its work with Traditional Birth Attendants, and the launching of its malaria intervention. Other positive developments have included the strengthening of its partnerships with MOH and community partners, as well as with other partners both in-country and at the headquarters level. Considerable work remains, however, including the definition of capacity and sustainability indicators to adequately document progress in those areas, and the initiation of activities to improve quality at the health facility level.